Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Health worker roles in providing safe abortion care and post-abortion contraception.

Bibliographic Source(s)

World Health Organization (WHO). Health worker roles in providing safe abortion care and post-abortion contraception. Geneva (Switzerland): World Health Organization (WHO); 2015. 81 p. [17 references]

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group
YES	Methodologist Involvement

	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
	Search Strategy
	Study Selection
	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
	Grading the Quality or Strength of Evidence
	Benefits and Harms of Recommendations
	Evidence Summary Supporting Recommendations
	Rating the Strength of Recommendations
	Specific and Unambiguous Articulation of Recommendations
	External Review
	Updating

Recommendations

Major Recommendations

Definitions for the strength of the recommendations (Recommended, Recommended in specific circumstances, Recommended in the context of rigorous research, Recommended against) and quality of evidence (High, Moderate, Low, Very Low) are provided at the end of the "Major Recommendations" field.

Refer to the "Additional Remarks" sections in the original guideline document for more information on individual topics. Refer to Table 2 in the original guideline document for health worker category definitions.

Management of Abortion and Post-abortion Care for Pregnancies in the First Trimester

Recommendations for Vacuum Aspiration for Induced Abortion

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended	There is evidence for the safety and effectiveness (moderate certainty) and for women's satisfaction with the overall abortion experience (low certainty). This option is feasible in both high- and low-resource settings, and may

Health Worker	Recommendation	Justification
		decrease inequities by extending safe abortion care to underserved populations.
Midwives	Recommended	There is evidence for the safety and effectiveness (moderate certainty) and for women's satisfaction with the overall abortion experience (low certainty). This task is recognized as a core competency in midwifery. Women often consider care received from midwives as more supportive (moderate confidence). The option has been shown to be feasible, including in low-resource settings.
Nurses	Recommended	There is evidence for the safety and effectiveness (low certainty) and for women's satisfaction with this option (low certainty). Women often consider care received from nurses as more supportive (moderate confidence). The option is feasible and may decrease inequities by extending safe abortion care to underserved populations.
Auxiliary nurses (AN) and auxiliary nurse midwives (ANM)	Recommended in specific circumstances This option is recommended in contexts where established mechanisms to include ANMs/ANs in providing basic emergency obstetric care or post-abortion care already exist.	Although there was insufficient direct research evidence for the effectiveness of this option, the benefits outweigh any possible harms. The option has also been shown to be feasible, including at scale in low-resource settings, and has the potential to decrease inequities by extending safe abortion care to rural and underserved populations.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	There is evidence for the effectiveness of components of the task, e.g., assessing uterine size with bimanual examination as part of medical abortion provision (low certainty). These professionals perform transcervical procedures such as intrauterine device (IUD) insertion in some settings. The benefits outweigh possible harms and the option has the potential to increase equitable access to safe abortion care in regions where these professionals constitute a significant proportion of the health workforce.
Pharmacists, pharmacy workers, lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

Management of Uncomplicated Incomplete Abortion/Miscarriage in the First Trimester with Vacuum Aspiration

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended	There is evidence for the safety and effectiveness of the provision of vacuum aspiration for induced abortion (moderate certainty; see previous table) by these health workers. The skills required for the management of uncomplicated incomplete abortion with vacuum aspiration are similar.
Midwives	Recommended	There is evidence for the safety and effectiveness of the provision of vacuum aspiration for induced abortion

Health Worker	Recommendation	Justification
		(moderate certainty; see previous table) by these health workers. The skills required for the management of uncomplicated incomplete abortion with vacuum aspiration are similar. The option appears to be feasible, including in low-resource settings.
Nurses	Recommended	There is evidence for the safety and effectiveness of the provision of vacuum aspiration for induced abortion (low certainty; see previous table) by these health workers. The skills required for the management of uncomplicated incomplete abortion with vacuum aspiration are similar. The option appears to be feasible, including in low-resource settings.
Auxiliary nurses and auxiliary nurse midwives	Recommended in specific circumstances This option is recommended in contexts where established health systems mechanisms involve ANMs/ANs in providing basic emergency obstetric care, and where referral and monitoring systems are strong.	There was insufficient direct research evidence for the safety and effectiveness of this option. However, the option of this type of health worker delivering emergency obstetric care (which includes removing retained products as a signal function) or post-abortion care using manual vacuum aspiration (MVA) has been shown to be feasible in programmes in several low-resource settings.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	There is evidence for the effectiveness of carrying out components of the task, e.g., assessing uterine size with bimanual examination as part of medical abortion provision (low certainty). These professionals perform transcervical procedures like IUD insertion in some settings. This option has the potential to increase equitable access to safe abortion care in regions where these professionals constitute a significant proportion of the health workforce.
Pharmacists, pharmacy workers, lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

The Provision of Medical Abortion (MA) in the First Trimester

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended	There is evidence for the effectiveness of carrying out components of the task, e.g., assessing gestation as part of MVA provision. There is also evidence that health worker types with similar or less comprehensive basic training (e.g., midwives, nurses, auxiliary nurse midwives) can provide MA safely and effectively (moderate certainty). The option is feasible and the potential to expand access to underserved populations is high.
Midwives	Recommended	There is evidence for the safety and effectiveness of this option (moderate certainty). More women are satisfied with the provider when midwives provide MA (moderate certainty). The option appears feasible and is already being implemented in several countries.

Health Worker	Recommendation	Justification
Nurses	Recommended	There is evidence for the safety and effectiveness, and for women's satisfaction with abortion services with this option (moderate certainty).
Auxiliary nurses and auxiliary nurse midwives	Recommended	There is evidence for the safety and effectiveness (moderate certainty) of this option. The option appears feasible and is already being implemented in some low-resource settings.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	There is evidence for the safety and effectiveness, and for women's satisfaction with this type of provider and services (low certainty). The benefits outweigh any possible harms, and the potential to reduce inequities in access to safe abortion care in regions where such professionals form a significant proportion of the health workforce is high.
Pharmacists	No recommendation for independent provision of MA; see next tables for recommendations made for subtasks.	Before making a recommendation on full independent provision of MA it is necessary to demonstrate the effectiveness and feasibility of the subtasks.
Pharmacy workers	Recommended against	There was no evidence for the safety, effectiveness, acceptability or feasibility of this option. However, it is important to note that as with all other drugs and medications, pharmacy workers should dispense mifepristone and misoprostol as indicated by prescription.
Lay health workers	No recommendation for the overall package; see next tables for recommendations made for subtasks.	Before making a recommendation on full independent provision of MA it is necessary to demonstrate the effectiveness and feasibility of carrying out the subtasks.

The Provision of Medical Abortion Subtasks in the First Trimester by Pharmacists

Subtask	Recommendation	Justification
Assessing eligibility for medical abortion	Recommended within the context of rigorous research	The approach has the potential to improve the triage of health care by screening and referral to appropriate health-care facilities. Rigorous research on this approach using simple tools and checklists is needed to address the uncertainties and to test the feasibility of the option in a programme setting.
Administering the medications and managing the process and common side-effects independently	Recommended within the context of rigorous research	Dispensing medications on prescription is within the typical scope of practice of these health workers and should be continued. However, well designed research is still needed on the effectiveness and feasibility in a programme setting of the approach of pharmacists independently making clinical judgments related to managing the process and its common side-effects. The approach has the potential to improve access as pharmacies are often women's first point of contact with the health system; however, the feasibility of developing referral linkages with the health system also needs to be studied.
Assessing completeness of the procedure and the need for further	Recommended within the context of rigorous research	This option has the potential to improve the triage of health care by screening women in need of further care. Research on this approach using simple tools like urine pregnancy tests and checklists is needed, as is research to

Subtask	Recommendation	Justification
clinic-based follow-up		test the feasibility of the option in a programme setting.

The Provision of Medical Abortion Subtasks in the First Trimester by Lay Health Workers

Subtask	Recommendation	Justification
Assessing eligibility for medical abortion	Recommended within the context of rigorous research	Fewer women may be assessed as eligible when lay health workers assess eligibility for medical abortion using simple checklists (low certainty). However, the option is promising and lay health workers are often involved, either formally or informally, in advising women who are seeking such care (moderate confidence). Well designed research is needed to refine the optimum tools and checklists needed and to test the feasibility in community settings.
Administering the medications and managing the process and common side-effects independently	Recommended within the context of rigorous research	The option has the potential to expand access to safe care, and well designed research has the potential to address any uncertainties around safety, effectiveness and feasibility.
Assessing completeness of the procedure and the need for further clinic-based follow-up	Recommended within the context of rigorous research	There is evidence that lay health workers can accurately assess abortion completeness using simple checklists (low certainty). Approaches using a urine pregnancy test as part of the assessment toolkit could yield better results and require further research.

Women's Role in Managing the Process of Medical Abortion

Woman's Role	Recommendation	Justification
Managing the entire process of medical abortion up to 84 days	No recommendation for the overall package; recommendations made for subtasks as below.	Individual components of the self-management of medical abortion have been tested; however, there is as yet insufficient evidence on using all three components together.
Self-assessing eligibility for medical abortion	Recommended within the context of rigorous research	Women may be more conservative in assessing eligibility using simple checklists (low certainty). However, the approach is promising and further work is needed on developing appropriate assessment tools.
Managing the mifepristone and misoprostol medication without direct supervision of a health-care provider	Recommended in specific circumstances This option is recommended in circumstances where women have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.	There is evidence that the option is safe and effective (low-certainty evidence from numerous studies, but using non-randomized designs given the strong preferences of women for one or the other option). More women report the method to be satisfactory when it is self-managed (low certainty). Women find the option acceptable and feasible (high confidence) and providers also find the option feasible (high confidence).
Self-assessing completeness of the abortion process using pregnancy tests and	Recommended in specific circumstances This option is recommended in circumstances in circumstances where both mifepristone and misoprostol are being used and where women have a source of	There is evidence that the option is safe and effective including in low-literacy, low-resource settings (moderate to high certainty).

Woman's Role	Recommendation	Justification
checklists	accurate information and access to a healthcare provider should they need or want it at any stage of the process.	

Management of Uncomplicated Incomplete Abortion/Miscarriage in the First Trimester with Misoprostol

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended	There is moderate-certainty evidence for the safety and effectiveness of medical management of incomplete abortion by midwives and moderate-certainty evidence for the effectiveness of medical abortion provision by health worker types with similar or less comprehensive basic training. Additionally, there is direct evidence that these health workers can assess gestational age as part of MVA provision. The option is feasible and the potential to expand access to underserved populations is high.
Midwives	Recommended	There is evidence from a low-resource setting for the safety and effectiveness (moderate certainty) of this option and for women's overall satisfaction with the provider (moderate certainty) when midwives manage incomplete abortion. The option appears feasible and has the potential to reduce inequities in access to safe abortion.
Nurses	Recommended	There is evidence for the safety, effectiveness and satisfaction of providing medical abortion (moderate certainty; see table above), and the skills required for managing incomplete abortion with misoprostol are similar. The option appears feasible and has the potential to reduce inequities in access to safe abortion.
Auxiliary nurses and auxiliary nurse midwives	Recommended	There is evidence for the safety and effectiveness of the provision of medical abortion in the first trimester (moderate certainty; see table above), and the skills required for managing incomplete abortion with misoprostol are similar.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	There is evidence for the safety and effectiveness of the provision of medical abortion in the first trimester (low certainty; see table above), and the skills required for managing incomplete abortion with misoprostol are similar.
Pharmacists and pharmacy workers	Recommended against	There was insufficient evidence for the safety and effectiveness of this option. It is also not within the typical scope of practice of pharmacists or pharmacy workers to conduct a full evaluation to diagnose incomplete abortion or determine uterine size.
Lay health workers	Recommended within the context of rigorous research	There was no direct evidence for this option, but there is some evidence that lay health workers can use simple tools and checklists to determine gestational age or abortion completeness (low certainty). Such health workers are often involved in advising women seeking such care (moderate confidence). In general, lay health worker interventions are

Health Worker	Recommendation	Justification
		acceptable and have proved feasible in many contexts. The further development of tools and carrying out rigorous research can help to address some of the uncertainties associated with this option.

Management of Abortion and Post-abortion Care for Pregnancies Beyond 12 Weeks

Provision of Dilatation and Evacuation (D&E) for Pregnancies Beyond 12 Weeks

Health Worker	Recommendation	Justification
Specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Non-specialist doctors	Recommended	There was no direct evidence for the safety or effectiveness of this option as compared to specialist doctors. However, it appears to be feasible in both high- and low-resource settings where D&E use is common. Such doctors also routinely perform other surgical procedures like caesarean section, vacuum extraction and tubal ligation. The potential benefits of this option outweigh the harms. A specialist provider may not always be available on-site and this option may increase the ability of the health system to provide care for women needing it.
Associate and advanced associate clinicians	Recommended within the context of rigorous research	There was no direct evidence for the safety or effectiveness. However, the potential benefits outweigh the possible harms and the option has the potential to reduce inequities in access and increase the likelihood of facilities being able to provide care in the second trimester. It is therefore important to test this option under research conditions.
Doctors of complementary systems of medicine	Recommended against	There was no direct evidence for the safety, effectiveness or feasibility of this option. The procedure requires skills beyond what is required for vacuum aspiration in pregnancies up to 12 weeks and the procedure is usually performed at facilities where specialist or non-specialist doctors are available.
Midwives, nurses, nurse-midwives, auxiliary nurse midwives, pharmacists, pharmacy workers, lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

Cervical Priming with Osmotic Dilators Prior to D&E

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	There is evidence for the safety and effectiveness of electric vacuum aspiration (EVA)/MVA provision (moderate certainty), which included cervical priming with osmotic dilators for select cases. This option may help optimize workflow within a facility and decrease waiting times for women.

Health Worker	Recommendation	Justification
Midwives	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	Although there was insufficient direct evidence for this option, midwives are recommended to do other transcervical procedures like inserting an IUD, and there is evidence that provision of MVA by midwives is effective and safe (moderate certainty; see table above). This option may help optimize workflow within a facility and decrease waiting times for women.
Nurses	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	Although there was insufficient direct evidence for this option, nurses are recommended to do other transcervical procedures like inserting an IUD, and there is evidence that the provision of MVA by nurses is safe and effective (moderate certainty; see table above). This option may help optimize workflow within a facility and decrease waiting times for women.
Auxiliary nurses and auxiliary nurse midwives	Recommended against	There was insufficient direct evidence for the safety and effectiveness of this option. These health workers are unlikely to be involved in second trimester abortion care.
Doctors of complementary systems of medicine	Recommended against	There was insufficient direct evidence for the safety and effectiveness of this option. These health workers are unlikely to be involved in second trimester abortion care.
Pharmacists, pharmacy workers, and lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

Cervical Priming with Medications Prior to D&E

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	There is evidence for health workers with similar or less comprehensive basic training (e.g., midwives, nurses, ANMs) using such medications to provide medical abortion (moderate certainty), and cervical priming is part of the training for MVA provision.
Midwives	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	There is evidence for the safety and effectiveness of midwives being able to use these medications to provide medical abortion (moderate certainty, see table above), and cervical priming is part of the training for MVA provision.
Nurses	Recommended in specific circumstances	There is evidence for the safety and effectiveness of nurses providing medical abortion using these medications (moderate certainty; see table

Health Worker	Recommendation	Justification
	It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	above), and cervical priming is part of the training for MVA provision.
Auxiliary nurses and auxiliary nurse midwives	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	There is evidence for the safety and effectiveness of these health workers providing medical abortion using these medications (moderate certainty; see table above), and cervical priming is also part of the training for MVA provision.
Doctors of complementary systems of medicine	Recommended in specific circumstances It is recommended that that this option be implemented if the priming is initiated under supervision of the health-care provider responsible for performing the D&E.	There is evidence for the safety and effectiveness of these health workers providing medical abortion using these medications (low certainty; see table above), and cervical priming is also part of the training for MVA provision.
Pharmacists and pharmacy workers	Recommended against	Although dispensing medications with a prescription is within the scope of practice of pharmacists, this procedure is for use in facility-based second trimester abortion.
Lay health workers	Recommended against	This procedure is for use in conjunction with a facility-based second trimester abortion. Lay health workers are unlikely to be involved with second trimester abortion care.

Provision of Medical Abortion Beyond 12 Weeks

Health Worker	Recommendation	Justification
Specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Non-specialist doctors	Recommended	There was insufficient direct evidence for this option; however, non-specialist doctors routinely carry out tasks of similar or greater complexity (e.g., conducting deliveries, manual removal of placenta, vacuum extraction). The potential benefits of this option outweigh the harms and the intervention has proven feasible in several settings. A specialist provider may not always be available on-site and this option may increase the ability of the health system to provide care for women needing it.
Associate and advanced associate clinicians	Recommended in specific circumstances This option is recommended in contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	There was insufficient direct evidence for this option; however, such professionals are considered as options for tasks of similar complexity, like vacuum extraction and manual removal of placentas. They are often present at higher-level facilities where second trimester care is provided. A trained specialist provider may not always be present at such a facility and the potential to sustain second trimester services is increased with more than one trained provider on site.
Midwives	Recommended in specific circumstances This option is	Although there was insufficient direct evidence for the effectiveness of the intervention as a whole, midwives are often responsible for the monitoring and care of the woman from the time of misoprostol administration to completion

Health Worker	Recommendation	Justification
	recommended in contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	of abortion, and women often find care provided by midwives to be more acceptable (moderate confidence).
Nurses	Recommended in specific circumstances This option is recommended in contexts where established and easy access to appropriate surgical backup and proper infrastructure is available to address incomplete abortion or other complications.	Although there was insufficient direct evidence for the effectiveness of the intervention as a whole, nurses are often responsible for the monitoring and care of the woman from the time of misoprostol administration to completion of abortion, and women often find care provided by nurses to be more acceptable (moderate confidence).
Auxiliary nurses and auxiliary nurse midwives	Recommended against	There was no direct evidence for the effectiveness, safety or acceptability of this option. These health workers are unlikely to be present at the higher-level facilities where such care is provided or be involved in second trimester abortion care.
Doctors of complementary systems of medicine	Recommended against	There was no direct evidence for the effectiveness, safety or acceptability of this option. These doctors are unlikely to be involved in second trimester abortion care and the procedure is performed at a higher-level facility where specialist/non-specialist doctors are usually present.
Pharmacists, pharmacy workers, and lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

Management of Non-life-threatening Complications

Initial Management of Non-life-threatening Post-abortion Infection

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians, midwives, nurses, auxiliary nurses, and auxiliary nurse midwives	Recommended	Although there was no direct evidence for the management of post-abortion infection, the management of puerperal sepsis with intramuscular (IM) antibiotics, which requires similar skills, is recommended as being within the typical scope of practice of these health workers
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to	There was no direct evidence for the management of post-abortion infection, but the basic training of these professionals covers the skills required for this task.

Health Worker	Recommendation	Justification
	maternal and reproductive health.	
Pharmacists, pharmacy workers, and lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

Initial Management of Non-life-threatening Post-abortion Haemorrhage

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians, midwives, and nurses	Recommended	Although there was no direct evidence for the management of post-abortion haemorrhage, the initial management of post-partum haemorrhage with intravenous (IV) fluids, which requires similar skills, is considered as being within their typical scope of practice.
Auxiliary nurses and auxiliary nurse midwives	Recommended	Although there was no direct evidence for the management of post-abortion haemorrhage, the initial management of post-partum haemorrhage with IV fluids, which requires similar skills, is a recommended task
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	There was no direct evidence for the management of post-abortion haemorrhage, but the basic training of these professionals covers the skills required for this task.
Pharmacists, pharmacy workers, and lay health workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.

Information about Safe Abortion and Contraception

Provision of Information on Safe Abortion

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors, associate and advanced associate clinicians, doctors of complementary systems of medicine, midwives, nurses, auxiliary nurses and auxiliary nurse midwives	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Pharmacists	Recommended	There is evidence for the effectiveness of provision of education and counselling on chronic illnesses (low to moderate certainty). These professionals are often consulted by women seeking advice on how to deal with

Health Worker	Recommendation	Justification
		delayed menstruation (moderate confidence). Pharmacists are qualified professionals and routinely provide information about medications.
Pharmacy workers	Recommended in specific circumstances This option is recommended only in contexts where it can be ensured that the pharmacy worker is under the direct supervision of a pharmacist and where access to a referral linkage with a formal health system exists	There was insufficient direct evidence for the effectiveness, safety and acceptability of this option. However, in many contexts, such workers are often consulted by women seeking information on how to deal with delayed menstruation (moderate confidence). Even though the effectiveness of training interventions with such workers is uncertain, the potential benefits of such workers being able to provide basic information outweighs the potential harms of them not providing information or providing incorrect information.
Lay health workers	Recommended	Lay health worker interventions in health promotion are generally well accepted and feasible in many contexts where there is a strong lay health worker programme (moderate confidence). The potential to expand equitable access to information and safe abortion care is high.

Pre- and Post-abortion Counselling

Provision of Pre- and Post-abortion Counselling

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors	Recommended	Within their typical scope of practice. No assessment of the evidence was therefore conducted.
Associate and advanced associate clinicians	Recommended	This task is a core element of provision of abortion or post-abortion care.
Midwives	Recommended	Counselling is a core competency for midwives and this task is a core element of provision of abortion or post-abortion care.
Nurses, auxiliary nurses and auxiliary nurse midwives	Recommended	This task is a core element of provision of abortion or post-abortion care.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	This task is a core element of provision of abortion or post-abortion care.
Pharmacists	Recommended against	Although pharmacists are qualified to provide information about the drugs they dispense and there is evidence of effectiveness (low certainty) in counselling patients on the management of chronic conditions, their scope of practice

Health Worker	Recommendation	Justification
		does not include surgical options, thus they are not well placed to provide counselling on all safe abortion/contraception methods. Additionally, pharmacies may not be suitable places in terms of the privacy required for providing pre- and post-abortion counselling, hence this option may not be feasible in most settings.
Pharmacy workers	Recommended against	There was no evidence for the safety, effectiveness or feasibility of this approach.
Lay health workers	Recommended in specific circumstances This option is recommended in limited circumstances in contexts where the health-care provider managing the procedure is unavailable to provide counselling or the woman needs additional support.	There was insufficient direct evidence for the effectiveness, acceptability and feasibility of this option, but lay health worker interventions are generally well accepted and feasible in many contexts, and lay health workers are often intermediaries between the formal health systems and women seeking abortion-related care (moderate confidence). These workers could play a supportive role to the main provider or counsellor.

Provision of Post-abortion Contraception

Insertion and Removal of an Intrauterine Device

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors, associate and advanced associate clinicians	Recommended	The recommendation comes from the *OptimizeMNH* guideline (see the "Availability of Companion Documents" field) where this task was considered as being within the typical scope of practice of these health workers.
Midwives and nurses	Recommended	The recommendation comes from the *OptimizeMNH* guideline.
Auxiliary nurse midwives	Recommended	The recommendation comes from the *OptimizeMNH* guideline.
Auxiliary nurses	Recommended within the context of rigorous research	The recommendation comes from the *OptimizeMNH* guideline.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	Their basic training generally covers the relevant skills needed for this task. This option is probably feasible and may promote continuity of care for women and increase access in regions where such professionals form a significant proportion of the health workforce.
Pharmacists and pharmacy workers	Recommended against	There was no direct evidence for the safety, effectiveness, acceptability or feasibility of this option.
Lay health workers	Recommended against	The recommendation comes from the *OptimizeMNH* guideline.

Insertion and Removal of Implants

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors, associate/advanced associate clinicians	Recommended	The recommendation comes from the *OptimizeMNH* guideline (see the "Availability of Companion Documents" field) where this task was considered as being within the typical scope of practice of these practitioners.
Midwives and nurses	Recommended	The recommendation comes from the *OptimizeMNH* guideline.
Auxiliary nurses and auxiliary nurse midwives	Recommended in specific circumstances This option is recommended within the context of targeted monitoring and evaluation.	The recommendation comes from the *OptimizeMNH* guideline.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health and where training in implant removal is given along with training in insertion.	There was insufficient direct evidence for the effectiveness of this option. However, the basic training of this cadre covers the relevant skills needed for this task. This option may promote continuity of care for women.
Pharmacists and pharmacy workers	Recommended against	There was no direct evidence for the safety, effectiveness, acceptability or feasibility of this option.
Lay health workers	Recommended within the context of rigorous research	The recommendation comes from the *OptimizeMNH* guideline.

Initiation and Continuation of Injectable Contraceptives

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors, associate/advanced associate clinicians, midwives, nurses	Recommended	The recommendation comes from the *OptimizeMNH* guideline (see the "Availability of Companion Documents" field) where this task was accepted as being within the typical scope of practice of these practitioners.
Auxiliary nurses and auxiliary nurse midwives	Recommended	The recommendation comes from the *OptimizeMNH* guideline.
Doctors of complementary systems of medicine	Recommended in specific circumstances This option is recommended only in contexts with established health system mechanisms for the participation of doctors of complementary systems of medicine in other tasks related to maternal and reproductive health.	The basic training of this cadre covers the relevant skills needed for this task, hence additional training needs would be minimal. This option may promote continuity of care for women.
Pharmacists	Recommended	Although the available evidence for effectiveness is of very low certainty, administering injections is within the typical scope of practice of pharmacists and the additional training needs for this task would be minimal. This option has the potential to increase women's choices and

Health Worker	Recommendation	Justification
Pharmacy workers	Recommended in specific circumstances This option is recommended only in contexts where the pharmacy worker is administering injectable contraceptives under direct supervision of a pharmacist.	reduce inequities in contraceptive access. There was no evidence for the effectiveness, acceptability or feasibility of this option. However, administering injections is within the typical scope of practice for trained pharmacy workers, thus the additional training needs would be not be high. This option has the potential to increase women's choices and reduce inequities in contraceptive access.
Lay health workers	Recommended in specific circumstances This option is recommended for implementation under targeted monitoring and evaluation.	The recommendation comes from the *OptimizeMNH* guideline.

Self-administration of Injectable Contraception

Self-administration of Injectable Contraceptives	Recommendation	Justification
Women (self-administration)	Recommended in specific circumstances This option is recommended in contexts where mechanisms to provide the woman with appropriate information and training exist, referral linkages to a healthcare provider are strong, and where monitoring and follow-up can be ensured.	There is evidence from high-resource settings that continuation rates for self-administered injectable contraceptives are similar to injectable contraceptives being provided by clinic-based providers (low certainty). The option may result in time and financial savings for women. There is evidence that some women prefer self-injection and the option may increase choice and autonomy in contraceptive use within a rights-based framework.

Tubal Ligation

Health Worker	Recommendation	Justification
Specialist doctors, non-specialist doctors, associate/advanced associate clinicians	Recommended	The recommendation comes from the *OptimizeMNH* guideline (see the "Availability of Companion Documents" field) where this task was accepted as being within the typical scope of practice of these practitioners.
Midwives and nurses	Recommended within the context of rigorous research	The recommendation comes from the *OptimizeMNH* guideline.
Auxiliary nurses and auxiliary nurse midwives	Recommended against	The recommendation comes from the *OptimizeMNH* guideline.
Doctors of complementary systems of medicine	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.
Pharmacists, pharmacy workers	Recommended against	Outside of their typical scope of practice. No assessment of the evidence was therefore conducted.
Lay health workers	Recommended against	The recommendation comes from the *OptimizeMNH* guideline, where this task was accepted as being outside of the typical scope of practice of these practitioners.

Definitions

Strength of Recommendation

Recommendation Category	Explanation
Recommended	The benefits of implementing this option outweigh the possible harms. This option can be implemented, including at scale.
Recommended in specific circumstances	The benefits of implementing this option outweigh the possible harms in specific circumstances. The specific circumstances are outlined for each recommendation. This option can be implemented under these specific circumstances.
Recommended in the context of rigorous research	There are important uncertainties about this option (related to benefits, harms, acceptability and feasibility) and appropriate, well designed and rigorous research is needed to address these uncertainties.
Recommended against	This option should not be implemented.

Quality of Evidence

The certainty of the evidence has been indicated where appropriate as follows:

High certainty: Further research is very unlikely to change confidence in the estimate of effect.
Moderate certainty: Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low certainty: Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very low certainty: The Guideline Development Group (GDG) is very uncertain about the estimate.

Confidence assessments of qualitative research evidence are referred to in the following terms:

High confidence: It is highly likely that the review finding is a reasonable representation of the phenomenon of interest.
Moderate confidence: It is likely that the review finding is a reasonable representation of the phenomenon of interest.
Low confidence: It is possible that the review finding is a reasonable representation of the phenomenon of interest.
Very low confidence: It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Counseling

Management

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Patients

Pharmacists

Physician Assistants

Physicians

Guideline Objective(s)

To provide evidence-based recommendations on the safety, effectiveness, feasibility and acceptability of a range of health workers in the delivery of recommended and effective interventions for providing safe abortion and post-abortion care and in providing post-abortion contraception

Target Population

Women who have an unintended pregnancy

Interventions and Practices Considered

Consideration of appropriate health care workers to provide abortion care and post-abortion contraception

Major Outcomes Considered

- Safety
- Effectiveness
- Satisfaction
- Acceptability
- Feasibility

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Evidence Retrieval

Evidence for safety, effectiveness and satisfaction was drawn from randomized controlled trials, non-randomized controlled trials, controlled before-and-after studies and interrupted-time-series studies. Evidence for acceptability came from qualitative or mixed-method studies with a qualitative component. For the evidence on feasibility, all documented information related to task shifting in abortion care in five countries (Bangladesh, Ethiopia, Nepal, South Africa and Uruguay) was collected. The countries were selected to represent a diversity of regions and examples where national or subnational programmes on task shifting related to abortion care are already being implemented.

Existing reviews that directly or indirectly addressed the questions of interest were identified and their usefulness for this guideline was assessed before a search for further evidence was initiated. Seven reviews addressing effectiveness, two reviews addressing acceptability and a feasibility case study synthesis were undertaken specifically for this guideline. In addition, findings from three existing systematic reviews on effectiveness of pharmacists in providing other types of health interventions, and six existing qualitative systematic reviews and multicountry studies of the implementation of similar health worker programmes for other maternal health tasks were also incorporated into the evidence base.

Search strategies were specific to each question – they are described in full in the respective reviews in Web Supplements 2 and 3 (see the "Availability of Companion Documents" field). In general, databases were searched from inception to 2014, without language filters and for low- and middle-income as well as high-income countries. The databases searched included the following: African Index Medicus, Chinese Biomedical Literature Database, CINAHL, Cochrane Database, ClinicalTrials.gov, EBSCO, EMBASE, Global Index Medicus, Index Medicus for South-East Asia, Index Medicus for WHO Eastern Mediterranean Region, LILACS, Ovid MEDLINE, Popline, PubMed, Western Pacific Regional Index Medicus.

A special effort was made to identify and include non-English language literature for the acceptability/feasibility outcomes and most of the documented materials for the case study on Uruguay were in Spanish. Reference lists of key articles were also hand searched and external experts were contacted to identify additional relevant studies, including reports of completed trials that had not yet been published. For the case study synthesis, documented literature was supplemented with interviews with knowledgeable in-country experts. Figure 2 in the original guideline document charts the geographical spread of the data included in the evidence base. Titles and abstracts were screened by two members of the review team and the full texts of shortlisted articles were further screened to determine if they met inclusion criteria.

Number of Source Documents

See Figure 2 in the original guideline document for the evidence base informing the recommendations. See Web Supplements 1 to 3 (see the "Availability of Companion Documents" field) for numbers of studies identified and included for each systematic review.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

The certainty of the evidence has been indicated where appropriate as follows:

> High certainty: Further research is very unlikely to change confidence in the estimate of effect.
> Moderate certainty: Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
> Low certainty: Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
> Very low certainty: The Guideline Development Group (GDG) is very uncertain about the estimate.

Confidence assessments of qualitative research evidence are referred to in the following terms:

> High confidence: It is highly likely that the review finding is a reasonable representation of the phenomenon of interest.
> Moderate confidence: It is likely that the review finding is a reasonable representation of the phenomenon of interest.
> Low confidence: It is possible that the review finding is a reasonable representation of the phenomenon of interest.
> Very low confidence: It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Evidence Synthesis

For the safety and effectiveness findings, the Grading of Recommendations Assessment, Development and Evaluation (GRADE) profiler, GRADEpro, was used to create evidence profiles and Summary of Findings tables. Forest plots were made to graphically illustrate the relative risk estimates. Meta-analyses were performed when more than one trial reported risk estimates relevant to outcomes. For qualitative reviews, two individuals identified the key findings relevant to the scope of the guidance. Findings were organized into Summary of Findings tables.

Assessment of Confidence in the Evidence

The certainty (i.e., the extent to which one can be confident that an estimate of the effect or association is correct) of the benefits and harms outcomes was assessed using the GRADE approach. Five criteria – study limitations, consistency of effect, imprecision, indirectness and publication bias – were used to assess the certainty for each outcome. Evidence was downgraded by one level for serious and by two levels for very serious limitations. Assessments were made independently by two GRADE methodologists.

Confidence in findings from the reviews of qualitative studies was assessed with the Confidence in the

Evidence from Reviews of Quality Research (CERQual) tool, utilizing an approach similar to GRADE. Each review finding was assessed on four factors:

- The methodological limitations of the individual qualitative studies contributing to the review finding, assessed using an appropriate qualitative critical appraisal tool;
- The relevance of a review finding, assessed by the extent to which the supporting evidence is applicable to the context specified in the review question;
- The coherence of each review finding, assessed by the extent to which the review finding was based on data that were similar across multiple individual studies and/or incorporated convincing explanations for any variations;
- The adequacy of data supporting the review finding, assessed by determining the degree of richness and/or scope, as well as the quantity of data supporting a review finding.

An overall judgment of the confidence in each review finding was made, based on all of the above. Where existing systematic reviews were used, confidence assessments as reported in the original reviews were used. Assessing the confidence in each finding was not possible for the case study synthesis given that these findings were based on a wide range of evidence types.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Contributors and Their Roles

The work was coordinated by the Responsible Officer at the Department of Reproductive Health and Research. Within the World Health Organization (WHO), work on preventing unsafe abortion is housed solely within this Department, hence the WHO Steering Group comprised members of this Department, with additional representation from the Department of Maternal, Newborn, Child and Adolescent Health and from WHO regional offices. Inputs were sought from other units at WHO as needed. The Steering Group managed the day-to-day activities of developing the guideline, developed the guideline questions, participated in the evidence retrieval and synthesis, and developed the Evidence to Decision (EtD) frameworks and draft recommendations. The Responsible Officer drafted the guideline with input from the Core Evidence Team and Steering Group.

The Core Evidence Team comprised experts from the Norwegian Knowledge Centre, Oslo. They provided oversight on methodological issues and the evidence retrieval and syntheses, and were responsible for the Grading of Recommendations Assessment, Development and Evaluation (GRADE) and Confidence in the Evidence from Reviews of Qualitative Research (CERQual) assessments of the certainty of evidence. They also worked with the Steering Group to draft the PICO questions and the EtD frameworks. Other experts provided technical input as needed. For example, an economist advised on resource use issues and an additional GRADE methodologist provided a second independent assessment of certainty.

The Guideline Development Group (GDG) comprised 18 members (10 women, 8 men) and included diverse expertise but with a particular focus on health systems and on regions of the world where the need for task sharing in abortion care is a high priority. The GDG provided input into the development of the scope of the guideline and the formulation of the questions and in reviewing the evidence and making recommendations. They also reviewed and approved the final guideline. In addition to ongoing consultations via email, Skype and GoToMeeting, two in-person meetings with the GDG were held in Geneva (November 2013 and October 2014).

Scoping and Formulation of the Guideline Questions

The initial list of tasks and health worker types to be considered for the guideline was developed on the basis of input and insights gained from previous technical consultations and regional meetings on safe

abortion in Riga, Latvia (May 2012), Addis Ababa, Ethiopia (September 2012), Kathmandu, Nepal (September 2012), and Nairobi, Kenya (November 2012). Additionally, an online questionnaire was sent to a purposively selected group of approximately 90 knowledgeable individuals to help define some of the relevant health worker categories, country-level practices and health worker roles. Responses were received from 35 people many of whom provided further input on national policies relating to health worker roles. The preliminary list was finalized in consultation with the GDG.

Formulation of Questions

Agreed on questions on health worker–task combinations were formulated in PICO (population, intervention, comparator, outcome) format. The prioritized outcomes were as follows:

Benefits and harms:

Safety: serious adverse events, complications (specific to the task);

Effectiveness (specific to the task);

Satisfaction of women receiving care with the overall services/health worker providing the care.

Acceptability:

Findings reported in qualitative research regarding the extent to which a task-shifting intervention is considered to be reasonable or adequate among women potentially or actually receiving abortion care, and among health workers potentially or actually delivering this care.

Feasibility:

Findings from qualitative studies on factors affecting implementation of task-shifting programmes at scale

The specific operationalization of these concepts for each health worker–task combination can be found in the supplementary annexes (Web Supplement 2, Web Supplement 3 [see the "Availability of Companion Documents" field).

Moving from Evidence to Recommendations

In order to follow a systematic process that explicitly considers the various factors that inform decisions on recommendations, the (EtD) frameworks developed by the Developing and Evaluating Communication Strategies to Support Informed Decision and Practice Based on Evidence (DECIDE) collaboration were used.

One framework was prepared for each question using a pre-set template. All systematically synthesized evidence as well as additional information was summarized into the following sections:

Background information:

This section contains information about the PICO, the context and general information about the task.

Benefits and harms:

The section contains the Summary of Findings (SoF) tables on safety, effectiveness and satisfaction, a narrative description of the included studies, and relevant additional contextual information.

Acceptability:

This section contains the summary of key findings from qualitative studies regarding the extent to which a task-shifting intervention is considered to be reasonable among women potentially or actually receiving abortion care and among health workers potentially or actually delivering this care. Acceptability to women was prioritized in decision-making; health worker acceptability informed implementation considerations.

Feasibility:

This section contains the summary of key findings from qualitative research and from country case studies regarding the extent to which a task-shifting intervention is capable of being accomplished or implemented. The focus was on the feasibility of the intervention from a health system perspective, as well as on broader social, legal and political factors.

Resources:

This section contains a summary of all resource-related outcomes reported within the studies that were selected for the safety and effectiveness evidence, and a qualitative assessment of resource needs in terms of training, supplies, referrals, supervision and monitoring, time and health worker remuneration. A health systems perspective was used in considering resource use, but especially for self-assessment and self-management approaches, resource use by women was also considered.

No formal cost analysis was conducted as such analyses tend to be very context specific; nor was a systematic search and evaluation of resource use information undertaken.

Overall recommendations and decisions.

Implementation considerations.

Research needs.

Using the framework, separate judgments were made for each of the criteria, i.e., the balance of benefits and harms, acceptability, feasibility and resource use. The overall recommendation considered all of these factors as relevant. This is particularly important as this guideline is related to health systems. The complete EtD frameworks are available in Web Supplement 1.

Use of the Frameworks for Decision-making

Draft EtD frameworks were prepared by the Steering Group and Core Evidence Team. These were reviewed by the GDG and recommendations finalized during the meeting in October 2014. In addition to the frameworks, the GDG also had access to all the evidence profiles and supplementary materials.

Decisions at the GDG meeting were consensus driven. The Chair allowed for discussion of differing views on recommendation options and the final decision was based on majority opinion, provided the panel members with opposing views were willing to agree to this outcome. An option for noting dissenting opinions was available, but it did not need to be used, nor did voting need to be resorted to.

Document Preparation

The Responsible Officer at WHO worked with a consultant to write the draft guideline.

Rating Scheme for the Strength of the Recommendations

Recommendation Category	Explanation
Recommended	The benefits of implementing this option outweigh the possible harms. This option can be implemented, including at scale.
Recommended in specific circumstances	The benefits of implementing this option outweigh the possible harms in specific circumstances. The specific circumstances are outlined for each recommendation. This option can be implemented under these specific circumstances.
Recommended in the context of rigorous research	There are important uncertainties about this option (related to benefits, harms, acceptability and feasibility) and appropriate, well designed and rigorous research is needed to address these uncertainties.
Recommended against	This option should not be implemented.

Cost Analysis

No formal cost analysis was conducted as such analyses tend to be very context specific; nor was a systematic search and evaluation of resource use information undertaken.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Twelve individuals, external to the guideline development process and chosen to reflect end-users from priority regions or those with methodological expertise, served as external peer reviewers for the draft guideline.

The Guideline Development Group (GDG) reviewed the draft and their feedback was incorporated. The guideline was also reviewed by external peer reviewers unconnected with the process of guideline development. They provided structured feedback on accuracy, presentation, implementation considerations and on the overall usefulness of the guideline. No serious factual errors affecting recommendations were noted by the peer reviewers.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Moving beyond specialist doctors to involve a wider range of health workers is an increasingly important public health strategy. Planned and regulated task shifting and task sharing can ensure a rational optimization of the available health workforce, address health system shortages of specialized health-care professionals, improve equity in access to health care and increase the acceptability of health services for those receiving them.

See the Web supplements (see the "Availability of Companion Documents" field) for the evidence base for benefits and harms of specific interventions. See also the "Justification" columns in the tables in the "Major Recommendations" field.

Potential Harms

- Side effects of agents used for medical abortion
- Complications of abortion procedures (infection, haemorrhage)

See the Web supplements (see the "Availability of Companion Documents" field) for the evidence base for benefits and harms of specific interventions.

Qualifying Statements

Qualifying Statements

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

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While legal, policy and regulatory contexts vary, abortion is legal at least to save the life of the woman in almost all countries and more than two thirds of countries have one or more additional grounds for legal abortion. The provision of care for complications (post-abortion care) is always legal. Thus, these recommendations are relevant across a diverse range of settings. They are also relevant in both high- and low-resource settings, as the need to make care more accessible and rationalize the use of available health resources exists in both these contexts.

Implementation of the Guideline

Description of Implementation Strategy

General Implementation Considerations

Implementation considerations specific to individual tasks have been highlighted along with the relevant recommendation in the original guideline document.

A complete discussion of the implementation considerations for safe abortion care is given in *Safe abortion: technical and policy guidance for health systems* and in the *Clinical practice handbook for safe abortion*. Considerations for the implementation of contraceptive services can be found in *Ensuring human rights in the provision of contraceptive information and services*. A discussion of general considerations for task shifting in maternal health and family planning can be found in the *OptimizeMNH guideline* (see the "Availability of Companion Documents" field). Findings from the qualitative reviews on acceptability and feasibility undertaken for this guideline also identified numerous facilitators and barriers to implementation; a complete summary of these findings is presented in Web Supplement 3 (see the "Availability of Companion Documents" field).

It is essential that task shifting and the overall expansion of health worker roles takes place as part of a planned and regulated strategy accompanied by appropriate mechanisms for training, certification and ongoing monitoring and support, and not as an opportunistic or de facto transfer of tasks because of the unavailability or the reluctance of a particular group of professionals to provide care.

Stakeholder involvement and working with professional associations across different levels of health worker groups is important in fostering trust, support for complementary roles and to create an enabling environment. The perceptions and attitudes of particular stakeholders can greatly influence the implementation of task shifting for abortion care. Addressing the concerns of more specialized providers who may be uncomfortable about shifting or sharing of tasks traditionally within their domain is important, as is addressing the concerns of health workers who will need to take on these additional

roles. The latter may have legitimate concerns about workloads, remuneration and professional roles, and may also not always be supportive of or willing to be involved in providing abortion or post-abortion care or contraception.

Competency-based training is a key prerequisite in building confidence and preparing health workers for new roles. The learning curve required for a new skill to be fully acquired, and therefore the time lag needed for newly introduced interventions to reach optimum effectiveness, should not be underestimated. Over time, mechanisms to include the training in pre-service curricula are important to sustain task shifting at scale.

The training must address not only the specific tasks but also issues related to abortion and contraception more broadly, including an understanding of local laws. Training must aim to promote respectful care for women irrespective of the personal beliefs of individual health workers. Conscientious objection, where allowed, should be regulated, and provision of alternate care for the woman ensured.

Changes need to be developed in regulatory structures or mechanisms for health workers to access the necessary commodities and supplies within a health system setting.

Implicit in the implementation of these recommendations is the shift of services for early abortion care to the primary care level. Initial investments in strengthening the infrastructure to make that shift are likely to result in long-term gains. Self-management approaches and the involvement of pharmacists or lay health workers requires special attention to creating referral linkages (as these may not exist) and developing training materials and tools, and mechanisms for a supply of quality drugs within a regulated and monitored health systems context.

Ongoing supportive mentoring is needed as well. Health workers providing care related to abortion may face additional stigma or professional isolation in some contexts and mechanisms for support are therefore particularly important, especially for health workers involved with second trimester abortion care and those working in rural areas.

Ensuring retention of trained health workers in rural or underserved areas can be particularly challenging. This requires, among other things, giving professional and personal support, ensuring security for health workers and providing adequate remuneration and non-monetary rewards. The guideline *Increasing access to health workers in remote and rural areas through improved retention* , though not directly addressing the issue of abortion, contains relevant recommendations that may be useful when implementing the recommendations of this guideline.

Effective implementation requires a functioning health system. However, the need for being inclusive of a range of health-care providers can often be even more acute in contexts where health systems are dysfunctional or disrupted (e.g., in humanitarian or crisis settings) and task shifting for abortion and contraception-related care in such settings should not be overlooked.

Refer to the original guideline document for information on dissemination and adaptation and monitoring guideline use.

Implementation Tools

Foreign Language Translations

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality

Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

World Health Organization (WHO). Health worker roles in providing safe abortion care and post-abortion contraception. Geneva (Switzerland): World Health Organization (WHO); 2015. 81 p. [17 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2015

Guideline Developer(s)

World Health Organization - International Agency

Source(s) of Funding

Commercial entities were not involved in developing the guideline nor was funding from such sources used.

Guideline Committee

Guideline Development Group (GDG)

Composition of Group That Authored the Guideline

Guideline Development Group (GDG) Members: Nana Yaa Appiah, Founder and Programs Director, Ghana Women's Voices Foundation, Ghana (African Region); Katherine Ba-Thike, Independent, Myanmar (South-East Asia Region); Marge Berer, Founder and Editor, *Reproductive Health Matters*, United Kingdom (European Region); Sadia Chowdhury (*GDG Chair*), Executive Director, BRAC Institute of Global Health,

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Financial Disclosures/Conflicts of Interest

Declarations of Interest

All members of the Guideline Development Group (GDG), the Core Evidence Team, peer reviewers and consultants were required to complete the standard World Health Organization (WHO) Declaration of Interest (DOI) form. GDG members completed the form prior to each of the meetings they attended and were also instructed to let the Secretariat know of any changes to their declared interests over time. The Steering Group evaluated the responses and discussed them with the Director of the Department. At the GDG meetings, the Chair presented a summary of the DOIs and all participants had the opportunity to confirm, append or amend any interests already declared.

Only two individuals – members of the GDG – declared secondary interests, which were not deemed to constitute a conflict of interest for the purpose of this guideline. No conflicts of financial interest or involvement with commercial entities were declared. The DOI forms have been electronically archived for future reference.

A complete list of all contributors, their affiliations, roles and DOIs is included in Annex A of the original guideline document.

Dr Kristina Gemzell Danielsson reported that she has received funding for clinical trials on abortion from the Nordic Society for Obstetrics and Gynaecology, and the European Society for Contraception and Reproductive Health. Dr Beverley Winikoff reported that her activities are covered by a grant from an anonymous donor (non-profit foundation). The grant is for work on medical abortion internationally and the same donor also supports research work at the WHO Department of Reproductive Health and Research.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available in several languages from the World Health Organization (WHO) Web site

. An interactive version of the guideline is available from the WHO Web site .

Availability of Companion Documents

The following are available:

Health worker roles in providing safe abortion care and post-abortion contraception. Executive summary. Geneva (Switzerland): World Health Organization (WHO); 2015. 14 p. Available from the World Health Organization (WHO) Web site .

Health worker roles in providing safe abortion care and post-abortion contraception. Web supplements. Geneva (Switzerland): World Health Organization (WHO). Available from the WHO Web site .

WHO recommendations: OptimizeMNH: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva (Switzerland): World Health Organization (WHO); 2012. 87 p. Available from the WHO Web site .

WHO handbook for guideline development. 2nd edition. Geneva (Switzerland): World Health Organization (WHO); 2014. 167 p. Available from the WHO Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on February 20, 2018. The guideline developer agreed to not review the content.

This NEATS assessment was completed by ECRI Institute on February 28, 2018. The guideline developer agreed to not review the content.

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